

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 389 63-050372

FILED JAN 3 1964

1. PLACE OF DEATH a. COUNTY <u>St. Louis,</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri,</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Gardenville,</u>		c. CITY OR TOWN <u>LeMay,</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Miller Nursing Home,</u>		d. STREET ADDRESS (If outside, give location) <u>510 Buckley Rd.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>G.</u> Last <u>Schottel,</u>			4. DATE OF DEATH Month <u>December</u> Day <u>19,</u> Year <u>1963</u>		
5. SEX <u>Male.</u>	6. COLOR OR RACE <u>White,</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/20/1885</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man-General Cable Co. - Retired</u>			11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri,</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>23 years</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Mathias Schottel,</u>			13b. MOTHER'S MAIDEN NAME <u>Anna Hafertepe,</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>[REDACTED]</u>		
17. INFORMANT <u>Herman W. Schottel,</u>			Address <u>510 Buckley Rd. Mo., LeMay,</u>		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia Lobar</u> DUE TO (b) <u>Carcinoma left lung primary</u> DUE TO (c) <u>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>8 mos.</u> <u>5 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Myocarditis</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>[REDACTED]</u>
20c. TIME OF INJURY Hour <u>12:30</u> a.m. <u>0</u> p.m. <u>0</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>May 5-1963</u>	20f. CITY, TOWN, OR LOCATION <u>LeMay</u>	COUNTY <u>St. Louis</u>	STATE <u>Mo.</u>
21. I attended the deceased from <u>May 5-1963</u> to <u>Dec. 18-63</u> and last saw her/him alive on <u>Dec. 18-63</u> . Death occurred at <u>12:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>2767 Garvin St. LeMay Mo.</u>	22c. DATE SIGNED <u>12-20-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/23/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery,</u>
23d. LOCATION (City, town, or county) <u>St. Louis County, Mo.</u>		23e. DATE RECD. BY LOCAL REG. <u>12-20-63</u>

24. FUNERAL DIRECTOR <u>Gebken-Benz Mortuary,</u>	25. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59
1 4000
2 4000
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9 1162.1
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13

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Van M. Sizemore

Licensed Embalmer No.

4343

P. O. Address

St Louis Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.